

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 08-24-04.

The IRO reviewed office visits levels I, II, III and IV, aquatic therapy, manual therapy technique, unlisted therapeutic procedure, vasopneumatic device, therapeutic exercises and unlisted cardiovascular service/procedure rendered from 08-25-03 through 03-10-04 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 01-19-05, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

CPT code 97110 dates of service 09-04-03, 09-08-03 and 09-11-03 denied with denial code "F" (fee guideline MAR reduction), dates of service 10-17-03, 10-20-03, 10-22-03, 10-29-03 and 11-03-03 denied with denial code "G" (unbundling), date of service 09-09-03 denied with denial code "N" (not appropriately documented). Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. Reimbursement not recommended.

CPT code 99080-73 dates of service 09-04-03 and 09-25-03 denied with denial code "N" (not appropriately documented). Per Rule 133.304(c) "A generic statement that simply states a conclusion such as "not sufficiently documented" or other similar phrases with no further description of the reason for the reduction or denial of payment does not satisfy the requirements of this section". Reimbursement is recommended per Rule 133.106(f)(1) in the amount of **\$30.00 (\$15.00 X 2 DOS)**.

Review of CPT codes 99212, 97113, 97530, 97139 and 97016 date of service 10-15-03 and codes 97545-WC and 97546-WC date of service 12-09-03 revealed that neither party submitted copies of EOBs. Per Rule 133.307(e)(2)(B) the requestor did not provide convincing evidence of carrier receipt of the providers request for EOBs. No reimbursement recommended.

CPT code 97140-59 date of service 10-31-03 denied with denial code "G" (unbundling). Per Rule 133.304(c) and 134.202(a)(4) the carrier did not specify which code 97140-59 was global to. Reimbursement is recommended per Rule 134.202(c)(1) in the amount of **\$34.05 (\$27.24 X 125%)**.

CPT code 97545-WC date of service 12-01-03 denied with denial code "A" (preauthorization required but not requested). The requestor obtained preauthorization (HORT11242003-001). Per Rule 134.600(b)(1)(B) "the carrier is liable for for all reasonable and necessary medical costs relating to the health care". Reimbursement is recommended per Rule 134.202(5)(B)(i) in the amount of **\$72.00**.

CPT code 97546-WC date of service 12-01-03 denied with denial code "A" (preauthorization required but not requested). The requestor obtained preauthorization (HORT11242003-001). Per Rule 134.600(b)(1)(B) "the carrier is liable for for all reasonable and necessary medical costs relating to the health care". Reimbursement is recommended per Rule 134.202(5)(B)(i) in the amount of **\$72.00**.

CPT code 99080-73 date of service 12-01-03 denied with denial code "H" (half payment/please resubmit with complete information re:work status per TWCC rule 129.5 part III is blank; no f/up or referral). The requestor did not submit documentation for review. No additional reimbursement recommended.

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the Medicare program reimbursement methodologies effective August 1, 2003 per Commission Rule 134.202(c), plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 09-04-03, 09-25-03, 10-31-03 and 12-01-03in this dispute.

This Findings and Decision and Order are hereby issued this 28th day of February 2005.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

Enclosure: IRO Decision

February 18, 2005

Texas Workers Compensation Commission
MS48
7551 Metro Center Drive, Suite 100
Austin, Texas 78744-1609

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-05-1140-01
TWCC #:
Injured Employee:
Requestor: Southeast Health Services
Respondent: T.A.S.B.
MAXIMUS Case #: TW05-0005

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to MAXIMUS for independent review in accordance with this Rule.

MAXIMUS has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the MAXIMUS external review panel who is familiar with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The MAXIMUS chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to MAXIMUS for independent review. In addition, the MAXIMUS chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a male who sustained a work related injury on _____. The patient reported that while at work he injured his back. The current diagnoses for this patient includes lumbar disc derangement with myelopathy, sciatica, stiffness of joint, and muscle spasms. Treatment for this patient's condition has included active therapeutic modalities consisting of therapeutic exercise lumbar Phase II strengthening and core stabilization exercises, treadmill activities, injections and active rehabilitation following.

Requested Services

Aquatic therapy, 99211/99212/99213/99214-levels I, II, III, & IV office visits, manual therapy technique, unlisted therapeutic procedure, vasopneumatic device, therapeutic exercises, unlisted cardiovascular service/procedure from 8/25/03 – 3/10/04.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Treatment Plan 2/12/04 – 3/12/04
2. Daily Notes 8/25/03 – 3/10/04
3. FCE/Reexams 8/27/03 – 12/30/03
4. Impairment Ratings 3/11/04, 4/8/04

Documents Submitted by Respondent:

1. No documents submitted

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The MAXIMUS chiropractor reviewer noted that this case concerns a male who sustained a work related injury to his back on _____. The MAXIMUS chiropractor reviewer also noted that the diagnoses for this patient have included lumbar disc derangement with myelopathy, sciatica, stiffness of joint, and muscle spasms. The MAXIMUS chiropractor reviewer further noted that treatment of this patient's condition has included active therapeutic modalities consisting of therapeutic exercises, lumbar Phase II strengthening and core stabilization exercises, treadmill activities, injections and active rehabilitation following. The MAXIMUS chiropractor reviewer explained that although this patient has received a significant amount of treatment, there is no documentation supporting that this treatment was beneficial to this patient. The MAXIMUS chiropractor reviewer also explained that without documentation demonstrating that this patient had improved with treatment rendered, the care in question is not medically necessary. Therefore, the MAXIMUS chiropractor consultant concluded that the aquatic therapy, 99211/99212/99213/99214-levels I, II, III, & IV office visits, manual therapy technique, unlisted therapeutic procedure, vasopneumatic device, therapeutic exercises, unlisted cardiovascular service/procedure from 8/25/03 – 3/10/04 were not medically necessary to treat this patient's condition.

Sincerely,
MAXIMUS

Elizabeth McDonald
State Appeals Department